The New York Otolaryngology Group
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Dizziness Questionnaire

Date:____________________

Name:____ DOB:____________________
Last First Middle

1. When did your dizziness begin?____

2. Currently, my dizziness…..(Check ALL that apply)
   [ ] Is Constant
   [ ] Is constant but waxes and wanes
   [ ] Comes and Goes

3. On average, how often does dizziness occur?
   More than once per day_____
   Once every ________ hours/days/weeks/months
   (circle one)

4. On average, how long does each dizzy spell last?
   [ ] Seconds
   [ ] Minutes
   [ ] Hours

5. My dizziness mostly consists of (Check ALL that apply):
   [ ] Spells of spinning with nausea
   [ ] Off-Balance sensation
   [ ] Light-headed or near-faint sensation
   [ ] Other. Please explain:____

6. Between episodes, I feel: (Check only one)
   [ ] Dizzy or off-balance all the time
   [ ] Normal
   [ ] Other. Please explain:____

7. Dizziness usually occurs:
   [ ] When I turn my head too quickly or in certain directions
   [ ] Spontaneously; nothing specifically brings them on
   Describe any particular head motion (or other movement) that causes dizziness:___________

   ____

8. When I roll over in bed (Check one):
   [ ] The room seems to spin every time
   [ ] The room seems to spin sometimes
   [ ] Nothing usually happen

over

Dizziness Questionnaire (page 2)

Name:____ DOB:__________________
Last First Middle

Functional Level Scale

Regarding your current state of *Overall* function, (not just during attacks) check the ONE that best applies:

1. [ ] My dizziness has no effect on my activities at all

2. [ ] When I am dizzy I have to stop what I am doing for a while, but it soon passes and I can resume activities. I continue to work, drive, and engage in any activity I choose without restriction. I have not changed any plans or activities to accommodate my dizziness.

3. [ ] When I am dizzy I have to stop what I am doing for a while, but it does pass and I can resume activities. I continue to work, drive and engage in most activities I choose, but I have had to change some plans and make some allowance for my dizziness.

4. [ ] I am able to work, drive, travel, take care of a family, or engage in most essential activities, but I must exert a great deal of effort to do so. I must constantly make adjustments in my activities and budget my energies. I am barely making it.

5. [ ] I am unable to work, drive, or take care of a family. I am unable to do most of the active things that I used to. Even essential activities must be limited, I am disabled.

6. [ ] I have been disabled for one year or longer and/or I receive compensation (money) because of my dizziness or balance problem.